# OFFICE OF THE SUFFOLK COUNTY EXECUTIVE OFFICE FOR PEOPLE WITH DISABILITIES WILLIAM J. LINDSAY COUNTY COMPLEX, BUILDING 158 725 VETERANS MEMORIAL HWY. P.O. BOX 6100 HAUPPAUGE, NY 11788-0099

**SCAT/PARATRANSIT** 

**APPLICATION** 

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

FRANK KROTSCHINSKY, ESQ., DIRECTOR
OFFICE FOR PEOPLE WITH DISABILITIES
WILLIAM J. LINDSAY COUNTY COMPLEX, BLDG. 158
725 VETERANS MEMORIAL HWY.

P.O. BOX 6100 HAUPPAUGE, NY 11788-0099 (631) 853-8333 (VOICE) (631) 853-5658 (TTY) (631) 853-8339 (FAX)

WWW.SUFFOLKCOUNTYNY.GOV



# SCAT PARATRANSIT OVERVIEW

Enclosed is an application for the Suffolk County Accessible Transit (SCAT) Paratransit system. SCAT is for people whose disability is so severe that it prevents them from using public buses. In compliance with the Americans with Disabilities Act of 1990 (ADA) Suffolk County provides curb-to-curb paratransit services for the SCAT Program to anyone who, because of physical or mental disability, is unable to use the regular, fixed route bus service. Age, distance from a bus stop, or inability to drive, are conditions which are not taken into consideration in making an eligibility determination.

This application form is intended to determine the circumstances under which the applicant can use the regular, fixed route bus system. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided. As part of the eligibility process, you may be required to undergo an in-depth interview. Failure to attend will result in denial of your application.

The applicant, or someone assisting him/her, must complete all the questions. A New York State licensed medical professional is required to complete the medical certification, this consists only of an M.D., D.O., P.A., N.P, or D.C. If you do not have access to a licensed medical professional, please call (631) 853-8333 for assistance.

When you have completed and signed the application, mail it (original only, we will **not** accept photocopies or faxes of this application) and **two identical black and white, or color passport size photographs** (no photocopies) to:

Suffolk County Office for People with Disabilities William J. Lindsay County Complex, Building 158 725 Veterans Memorial Hwy. P.O. Box 6100 Hauppauge, NY 11788-0099

You will be notified as to your eligibility by mail within 21 business days.

The specifications for the two original photographs are: clear, full face, front view. Your face should fit in a 1 by 1 1/4". Just print your name on the back of each photo and attach them to the application. Passport size photos will also be acceptable.

On the other side of this cover letter is information about Paratransit. If you have any questions, or need assistance filling out the application, please feel free to call us at (631) 853-8337 (voice), or if hearing impaired phone (631) 853-5658 (TTY).

# **REVISED SCAT-PARATRANSIT PROCEDURES & GUIDELINES 6/2017**

- To make a trip reservation, call the Suffolk County Accessible Transit (SCAT) Paratransit dispatcher at (631) 738-1150 (Voice) or (631) 981-0104 (TTY). <u>ALL RESERVATIONS ARE SUBJECT TO AVAILABILITY</u>. Riders are entitled to trips on a first-come, first-served basis.
- 2) Reservations may be made up to <u>5</u> days in advance and no later than one day prior to the day you want to ride, if available. Multiple reservations can be made at one time. Since reservations are on a first-come, first-served basis you may not always get the reservation you desire if those time slots have already been taken.
- 3) Reservations can be made between 7:00 a.m. and 5:00 p.m., Monday through Saturday. On Sundays, reservations can be made between 8:00 a.m. and 4:30 p.m.
- 4) The first daily pick-up will be 6:00 a.m. Monday through Saturday, (7:00 a.m. on Sunday), and the last daily pick-up will be 8:30 p.m. and later in those areas where SCT bus lines continue to operate later in the evening. Please note that since there is no bus service on certain holidays, there will be no Paratransit service on those days either, so please check with SCAT before you plan your trip.
- 5) The fare is \$4.00 one way (\$8.00 round trip). **Exact fare is required**.
- 6) For riders requiring a personal care attendant (PCA), as shown on ID card, the attendant will travel free. In addition to the PCA, one companion can also accompany the rider by paying the full fare. Additional companions may also accompany the rider, but only if sufficient vehicle capacity can accommodate them and they must also pay the full fare.
- Riders must have their I. D. card with them when using SCAT identifying them as ADA Paratransit eligible. (if you do not yet have your ID card, bring your eligibility certification letter along on the trip).
- 8) If you need to cancel your reservation, please do so as soon as possible, but at least two (2) hours before your scheduled pick-up time. In an emergency, call as soon as possible. However, riders who are repeat no shows or cancel excessively risk having their riding privileges suspended or revoked.
- Service is curb-to-curb. SCAT may also approve providing additional, limited assistance between curbside and a building's entrance along an accessible path when requested at the time trip reservations are made, in accordance with the Origin to Destination Policy.
- 10) Drivers are not required to carry packages for you. Maximum number of packages passengers are permitted to bring on a single boarding is determined on what they can safely carry on and off the vehicle. While on board the vehicle packages must be stored in a location that does not block path of travel within the vehicle, or interfere with safety features, or securement of other passengers.
- 11) All pick-up and drop-off locations must be within Suffolk County, NY. Service is no longer limited to be within <sup>3</sup>/4 of a mile of a Suffolk County Transit route. There is no service on Shelter Island. Trips that begin and end in Town of Huntington are handled by the HART paratransit system.
- 12) Please note the SCAT bus has a half-hour window, where it can show up 15 minutes before or 15 minutes after your scheduled pick-up time. YOU MUST BE READY DURING THIS ENTIRE WINDOW BECAUSE THE BUS WILL NOT WAIT MORE THAN 10 MINUTES FOR YOU.
- 13) If you are able to use the public bus system for trips, we urge you to do so. It is less expensive for you and makes room for people who can only travel via Paratransit. Thank you for your cooperation.

# **PLEASE SAVE!**

SCAT PARATRANSIT APPLICATION FORM					
M F					
DATE OF BIRTH: / /					
LAST NAME FIRST NAME MI					
STREET ADDRESS:  APT/BLDG #:					
CITY: COUNTY: ZIP CODE:					
HOME PHONE ( ) - NUMBER ( ) - NUMBER					
NEAREST CROSS STREET					
EMAIL:					
MAILING ADDRESS: If different from above					
STREET ADDRESS:  APT/BLDG #:					
CITY: COUNTY: ZIP CODE:					
Do you require information and material given to you in any of the following ways?      Mark all that you need     □ Braille □ Large Print □ Audio Format □ Other:					
PLEASE GIVE US THE NAME AND TELEPHONE NUMBER OF SOMEONE WE CAN CALL IN AN EMERGENCY.  LAST NAME  FIRST NAME					
HOME PHONE ( ) - CELL NUMBER ( ) -					
DO NOT WRITE BELOW THIS LINE					
CERTIFICATION DATA					
ID# DATE RECEIVED  Date Issued:					
Expiration Date:					
Eligibility Category:					
Certifier:					
Comments:					
Page 1 of 9					

2. Please indicate below if you use a	ny or the rollowing	j mobility aldes or equipment.
O Cane		manual wheelchair
Orutches		opowered wheelchair
O long white cane (for the visua	lly impaired)	opowered scooter/cart
service/guide animal (describe	e)	respirator/oxygen tank
O walker		O other
O leg braces		O I don't require any assistive devices
•		e applicant if the wheelchair or scooter is mbined weight of the applicant and wheelchair
3. Have you ever used the fixed route  Orange Yes, I typically use fixed route bu		eek.
Yes, but only for trips I am familia	r with.	
○ Yes, I used to but stopped becau	ise	
Ono		
•	ed route is there s	something that might help you to ride the
buses? (Mark all that apply.)  () Yes, route and schedule informa	tion	O v
	ition.	Yes, buses with wheelchair lifts.
Yes, learning to use the buses.  Yes, if bus stops were closer to	where I live and where	Yes, a communication aid.
Yes, (describe):		•
No, none of these would help.		
5. How far from your home is the nea	rest bus stop?	
Less than I block	5 or more blocks	5
1-2 blocks	O I don't know	
3-4 blocks		
6. On your own or using an assistive	device, how far ca	n you travel?
I can get to the curb in front of	my house/apartmen	t
O I can travel up to 3 blocks (1 /4 r	mile)	
I can travel up to 6 blocks (1/2 r	mile)	
I can travel up to 9 blocks (3/4 r	mile)	
O I don't know.		

7. Please mark ALL the disabilities that prevent you the applicant from using the fixed route.

☐ AIDS	☐ Kidney Disease/Dialysis
☐ Alzheimer's Disease	☐ Legally Blind
☐ Asthma	☐ Lupus
☐ Arteriosclerosis	☐ Macular Degeneration
☐ Arthritis	☐ Cognitive Impairment
☐ Autism	☐ Multiple Sclerosis
☐ Cancer	☐ Muscular Dystrophy
☐ Cataracts	Other:
☐ Cerebral Palsy	☐ Panic Disorder
☐ Congestive Heart Failure	☐ Paraplegia
☐ COPD	☐ Parkinson's Disease
☐ Cortical Blindness	☐ Peripheral Vascular Disease
☐ Cystic Fibrosis	☐ Phobia
☐ Dementia	☐ Quadriplegic
☐ Diabetes (severe)	☐ Retinopathy
☐ Emphysema	☐ Schizophrenia
☐ Epilepsy (severe)	☐ Spina Bifida
☐ Heart Attack	☐ Stroke/Cerebral Trauma
☐ Head Trauma	☐ Thrombosis (chronic)
	☐ Totally Blind

8.	ow does your identified disability prevent you, the applicant from riding the fixed route buses? lease explain in DETAIL.				
9.	Is this condition permanent? YES NO				
	Is this condition temporary? YES NO				
	If temporary, what is the expected duration?				
	(Number of months)				
10	0. Does the applicant need to travel with their own Personal Care Attendant (PCA)?				
	□ No				
	☐ Sometimes				
11	I. Is the applicant able to travel to and from a bus stop?				
	Yes No				
	If no, please indicate all that apply:				
	☐ Cannot negotiate where there are no sidewalks?				
	☐ Cannot travel if there are no curb cuts.				
	☐ Cannot cross busy streets and intersections.				
E	☐ Cannot tolerate extreme temperatures.				
	☐ Cannot travel on surfaces covered with ice/snow.				
	☐ Cannot locate or identify bus stop due to a visual impairment.				
	☐ Easily becomes confused and may get lost.				
	☐ Other (please specify):				

person?	YES	NO
Find his/her way between familiar locations?		
Grasp coins, passes, railings, and handles?		
Climb up and down three 12 inch steps?		
Travel 3/4 mile to a bus stop?		
Identify the stop at your destination?		
Deal with unexpected situations or unexpected changes in routine?		
3. Do you use any other type of transportation service? (Please check the appropriate box)		
☐ Medicaid Transportation		
☐ Senior Transportation		
☐ Other (Please explain)		

### SCAT APPLICATION MEDICAL FORM

Dear Health Care Professional (M.D., D.O., P.A., N.P., or D.C. only):

You are being asked to provide information regarding this applicant's disability. The Federal Law is very specific about ADA Paratransit eligibility. The law restricts eligibility to individuals who:

- 1. As a result of their disability, cannot board, ride, or disembark from a regular bus or
- 2. Have a specific impairment-related condition which prevents them from getting to or from a bus stop or
- 3. Who need a wheelchair lift when a wheelchair lift-equipped bus is not available on the route that they need to travel.

PLEASE NOTE: This does not include persons who find it difficult or uncomfortable to get to and from bus stops. In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This application is intended to determine whether the applicant can use regular transit service (fixed route) or whether he/she requires curb-to-curb service. Please exercise care in evaluating applicants. Your evaluation must be based solely upon the applicant's ability to use regular transit. Carefully evaluating these criteria will ensure that reliable Paratransit service is available for those who truly require it. This form must be completed in its entirety; any question left blank will deem this form **void** and incomplete. Please write clearly and legible.

Please mark all the disabilities which prevent the applicant from using the fixed route bus service. Conditions which make it difficult or uncomfortable should not be checked.

The health care professional completing this application certifies that  of applicant), is a severely disabled person whose functional limitation is:			
1) Neuromuscular  ( ) Amputation of (specify) ( ) Cerebral Palsy ( ) Muscular Dystrophy ( ) Parkinson's Disease ( ) Spina Bifida ( ) Stroke ( ) Brain Injury ( ) Quadriplegia ( ) Multiple Sclerosis ( ) Paraplegia ( ) Polio ( ) Arthritis ( ) Other: ( ) None		2) Cardiovascular  ( ) Arteriosclerosis ( ) Asthma ( ) Cystic Fibrosis ( ) Heart Attack ( ) Emphysema ( ) Congestive Heart Failure ( ) Chronic Obstructive Pulmonary Disease ( ) Peripheral Vascular Disease ( ) Thrombosis (Chronic) ( ) Other:	
3) Vision (mark all that apply) One Eye Cataracts ( ) Glaucoma ( ) Macular Degeneration ( ) Retinal Detachment ( ) Retinopathy ( ) Totally Blind ( ) Legally Blind ( ) Other:	Both Eyes ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	4) General Medical ( ) AIDS ( ) Diabetes (severe) ( ) Cancer ( ) Lupus ( ) Epilepsy (severe) ( ) Kidney Disease/Dialysis ( ) Other:	

# SCAT APPLICATION MEDICAL FORM

<ul> <li>( ) Dementia</li> <li>( ) Head Trauma</li> <li>( ) Cognitive Impairment</li> <li>( ) Schizophrenia</li> <li>( ) Anxiety</li> <li>( ) Depression</li> <li>( ) Panic Attacks</li> <li>( ) None</li> </ul>
5a) Do the above conditions respond to medication?YesNo
<b>5b)</b> For anxiety/panic attacks please indicate on average the frequency and length of attacks. per day per week per month per year approximate duration
5c) Please describe the functional limitations caused by this impairment:
<b>6)</b> What disability <b>prevents</b> the applicant from riding the regular bus system? A detailed diagnosis is required. Please be specific. (Please do not use diagnostic codes).
7) How does this disability affect the applicant's functional ability <b>and</b> prevent him/her from riding the regular bus system? (Please explain in <b>detail</b> ):
(Please explain in detail):  8) Is this condition: Permanent ( ) Temporary ( )
(Please explain in detail):  8) Is this condition: Permanent ( ) Temporary ( ) If temporary, what is the expected duration? (number of months)
(Please explain in detail):  8) Is this condition: Permanent ( ) Temporary ( )

Page 7 of 9

### SCAT APPLICATION MEDICAL FORM

(License Number)

(Phone Number)

(Street Address)

(City)

11) Please specify the applicant's ability to independently perforn the following functions using the most effective mobility aid. Little or No Discomfort Severe pain or Impossible or likely to Difficulty and/or some impairment cause a serious difficulty medical crisis Find his/her way between familiar locations Handle money or tickets Give address and telephone number upon request Recognize a destination or landmark Ask for and understand directions Travel 200 ft. (city block) Travel ¼ mile (three blocks) Deal with unexpected situations or unexpected changes in routine Safely and effectively travel through crowded facilities Applications with illegible or incomplete information will be returned and deemed void. I also certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis. Signed this \_\_\_\_\_\_ day of \_\_\_\_\_\_, 20\_\_\_\_\_ (Name of Physician) Please place Medical office stamp here. (Signature of Physician)

Page 8 of 9

(Zip)

(State)

Please note: Only the original forms of this document will be accepted.

### APPLICANT'S CERTIFICATION, CONSENT OF RELEASE OF APPLICATION INFORMATION

I, the applicant, understand that the purpose of this application form is to determine my eligibility to use the SCAT System. I agree to release the information requested to SCAT and any eligibility review panel and understand that the information contained herein will be treated confidentially. I understand that SCAT reserves the right to request additional information at its discretion. By signing, I authorize the licensed medical professional who signed this application to use and/or disclose certain protected health information (PHI) about me to Suffolk County Office for People with Disabilities. The information will be used or disclosed for the following purpose: To determine eligibility to use the SCAT paratranist service.

I understand that my application will be returned if it is **not complete**. I confirm that all the information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to the revocation of my certification. I understand that a false statement made herein may result in the rejection of my application for Paratransit service.

I understand the application process can take up to 21 days from the time SCAT receives a completed application. If my application is returned for clarification or additional information, this can delay the process.

I agree to notify Suffolk County Office for People with Disabilities at (631) 853-8333 if I no longer need Paratransit for any reason, including a change in my ability to use bus service. I also understand that failure to adhere to the policies and procedures for using Paratransit may be grounds for suspending or revoking my eligibility to participate in this program.

In the event that I apply for Paratransit eligibility in another community, I hereby authorize SCAT Paratransit to release the information on my SCAT application to such agency.

CERTIFICATION: The information I have given on this application is true to the best of my knowledge.

False statements are punishable under Section 210.45 of the Penal Law.

Signature of Applicant	
Printed name of applicant	Date
Signature of preparer (if other than applicant)	Date
Printed name of preparer, relationship or agency name	

This Application form must be completed and sent, together with two 1" x 1 1/4" identification-type photo or passport photos as described in the cover letter to:

SCAT
c/o Suffolk County Office for People with Disabilities
William J. Lindsay County Complex, Bldg. 158
725 Veterans Memorial Hwy., P.O. Box 6100
Hauppauge, NY 11788-0099
(631) 853-8333 (VOICE)
(631) 853-5658 (TTY)